General Assembly **Substitute Bill No. 678**

January Session, 2009 *____SB00678PH___032309___*

AN ACT IMPLEMENTING CHRONIC DISEASE MANAGEMENT AND WELLNESS AND PREVENTION STRATEGIES TO REDUCE HEALTH CARE COSTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2011*) (a) There is hereby created as a body politic and corporate, constituting a public instrumentality and political subdivision of the state created for the performance of an essential public and governmental function, the Connecticut Health Care Cost Containment Authority which is empowered to carry out the purposes of the authority, as defined in subsection (b) of this section, which are hereby determined to be public purposes for which public funds may be expended. The Connecticut Health Care Cost Containment Authority shall not be construed to be a department, institution or agency of the state.

(b) "Purposes of the authority" means the purposes of the authority expressed in and pursuant to this section, including with respect to the promotion, planning and designing, developing, assisting, acquiring, constructing, reconstructing, improving, maintaining and equipping and furnishing of health care, health care information technology and the health care delivery system and assisting directly or indirectly in the financing of the costs thereof.

(c) The Connecticut Health Care Cost Authority shall develop a

community-based health care utility model that shall reform the delivery of health care services in the state and finance the procurement of the technology that is required for the implementation of a comprehensive chronic disease management program and a wellness and prevention program administered through use of medical homes. Such model shall: (1) Prioritize the use of medical homes to improve outcomes for those who are chronically ill; (2) place emphasis on the use of case management services, disease management and care coordination; (3) leverage federal dollars to the maximum extent permissible to establish a viable health information exchange throughout the state; (4) reduce reliance on emergency room care as a means of accessing health care; (5) promote preventive care and wellness programs; (6) promote shared decision making between health care providers and their patients; and (7) provide incentives to health care providers who demonstrate improved health outcomes for patients through implementation of the practices set forth in this subsection.

Sec. 2. (NEW) (*Effective July 1, 2011*) (a) As used in this section and section 3 of this act:

(1) "Shared decision making" means a process whereby a physician or other health care provider discusses with a patient, or his or her representative, the information specified in this section with the use of a patient decision aid and such patient shares personal information with the health care provider for purposes of evaluating treatment options and possible side effects associated with such treatment options; and

(2) "Patient decision aid" means a written, audio-visual, or online tool that provides a balanced presentation of the health condition and treatment options, benefits and harms associated with such treatment options, including, if appropriate, a discussion of the limits of scientific knowledge about health outcomes. Any such patient decision aid shall be certified by one or more national certifying organizations.

(b) If a patient while legally competent, or his or her duly authorized legal representative if such patient is not competent, signs: (1) A consent form, prepared in language that the patient could reasonably be expected to understand that contains: (A) The nature and character of the proposed treatment; (B) the anticipated results of the proposed treatment; (C) the recognized possible alternative forms of treatment, including nontreatment; (D) the recognized serious possible risks, side effects and complications associated with such treatment; (E) anticipated benefits of such treatment; and (F) a statement that advises the patient of the actions that he or she should take should such patient experience any side effects or complications associated with such treatment; or (2) a statement that such patient has made an informed decision not to be apprised of the elements set forth in subdivision (1) of this subsection; then such signed consent form or signed statement of the patient's informed decision not to be apprised of treatment options shall constitute prima facie evidence that such patient provided informed consent to the health care provider for the treatment administered or alternatively made an informed decision not to be apprised about treatment options. The health care provider shall ensure that the patient is immediately provided with a copy of any statement signed pursuant to the provisions of this subsection. A patient who signs such consent form or statement indicating that such patient has made an informed decision not to be apprised of treatment options shall have the burden of rebutting by a preponderance of the evidence that such consent was not in fact informed consent or that such informed decision not to be apprised of treatment options was not in fact an informed decision.

(c) If a patient while legally competent, or his or her representative if he or she is not competent, signs an acknowledgement of shared decision making, such acknowledgement shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and such patient shall have the burden of rebutting by clear and convincing evidence that such consent was not in fact informed consent. An acknowledgement of shared decision

making shall include: (1) A statement that the patient, or his or her representative, and the health care provider have engaged in shared decision making as an alternative means of satisfying informed consent requirements by law or professional accreditation standards; (2) a brief description of the services that the patient and provider jointly have agreed will be furnished on the patient's behalf; (3) a brief description of the patient decision aid or aids that have been used by the patient and provider to address: (A) High-quality, up-to-date information about the patient's condition, including, treatment options, benefits and harms associated with such treatment options, and, if appropriate, a discussion of the limits of scientific knowledge about health outcomes; (B) values clarification that assists the patient in selecting treatment options that conform with the patient's values and preferences; and (C) guidance in the deliberative decision process, that is designed to improve the patient's involvement in such decision process; (4) a statement that the patient, or his or her representative, understands the risk or seriousness of the disease or condition to be prevented or treated, the available treatment alternatives, including nontreatment, and the risks, benefits and uncertainties of the treatment alternatives, including nontreatment; (5) a statement that advises the patient of the actions that he or she should take should such patient experience any side effects or complications associated with such treatment; and (6) a statement certifying that the patient, or his or her representative, has had the opportunity to ask the provider questions and to have any questions answered to the patient's satisfaction, and that indicates the patient's intent to receive the identified services. A health care provider shall ensure that a patient who signs an acknowledgement of shared decision making is immediately provided with a copy of the signed document.

(d) A health care provider's failure to use a prescribed form shall not be admissible as evidence of failure to obtain informed consent. A health care provider's failure to engage in shared decision making, with or without the use of a patient decision aid, shall not be admissible as evidence of failure to obtain informed consent. There

shall be no liability, civil or otherwise, resulting from a health care provider's choice to obtain informed consent by means of the signed consent form described in subsection (b) of this section or the signed acknowledgement of shared decision making described in subsection (c) of this section.

Sec. 3. (NEW) (*Effective July 1, 2011*) (a) The Department of Public Health, in collaboration with the State Comptroller, shall develop and implement a shared decision-making demonstration project. The demonstration project shall be conducted at one or more multispecialty group practice sites providing state purchased health care.

(b) The demonstration project shall include the following elements: (1) Incorporation into clinical practice of one or more patient decision aids for one or more identified preference-sensitive care areas combined with ongoing training and support of involved health care providers and practice teams, preferably at sites with necessary supportive health information technology; and (2) an evaluation of: (A) The impact of the use of shared decision making with patient decision aids, including the use of preference-sensitive health care services selected for the demonstration project and expenditures for those services; (B) the impact on patients, including patient understanding of the treatment options presented and the affinity between patient values and the care received; and (C) patient and provider satisfaction with the shared decision-making process.

(c) As a condition of participating in the demonstration project, a participating practice site shall bear the cost of selecting, purchasing and incorporating the chosen patient decision aids into clinical practice.

(d) Not later than July 1, 2012, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, on the status of the demonstration project to the joint standing committee of the General Assembly having cognizance of

matters relating to public health.

Sec. 4. Section 20-7a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(a) Any practitioner of the healing arts who agrees with any clinical laboratory, either private or hospital, to make payments to such laboratory for individual tests or test series for patients shall disclose on the bills to patients or third party payors the name of such laboratory, the amount or amounts charged by such laboratory for individual tests or test series and the amount of his procurement or processing charge, if any, for each test or test series. Any person who violates the provisions of this section shall be fined not more than one hundred dollars.

(b) Each practitioner of the healing arts who recommends a test to aid in the diagnosis of a patient's physical condition shall, to the extent the practitioner is reasonably able, inform the patient of the approximate range of costs of such test.

(c) Each practitioner of the healing arts who (1) has an ownership or investment interest in an entity that provides diagnostic or therapeutic services, or (2) receives compensation or remuneration for referral of patients to an entity that provides diagnostic or therapeutic services shall disclose such interest to any patient prior to referring such patient to such entity for diagnostic or therapeutic services and provide reasonable referral alternatives. Such information shall be verbally disclosed to each patient or shall be posted in a conspicuous place visible to patients in the practitioner's office. The posted information shall list the therapeutic and diagnostic services in which the practitioner has an ownership or investment interest and therapeutic and diagnostic services from which the practitioner receives compensation or remuneration for referrals and state that alternate referrals will be made upon request. Therapeutic services include physical therapy, radiation therapy, intravenous therapy and rehabilitation services including physical therapy, occupational

therapy or speech and language pathology, or any combination of such therapeutic services. This subsection shall not apply to in-office ancillary services. As used in this subsection, "ownership or investment interest" does not include ownership of investment securities that are purchased by the practitioner on terms available to the general public and are publicly traded; and "entity that provides diagnostic or therapeutic services" includes services provided by an entity that is within a hospital but is not owned by the hospital. Violation of this subsection constitutes conduct subject to disciplinary action under subdivision (6) of subsection (a) of section 19a-17.

(d) A provider of anatomic pathology services shall not submit a bill for the provision of such services to any person or entity other than the patient, the responsible insurer of a third-party payor, or a governmental agency or such agency's public or private agent that is acting on behalf of the recipient of such services. For purposes of this subsection, "anatomic pathology services" means histopathology or surgical pathology, cytopathology, hematology, subcellular pathology or molecular pathology or blood banking service performed by a pathologist and "provider" means any person or organization that furnishes health care services and is licensed or certified to furnish such services pursuant to chapter 368a or chapter 370.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2011*	New section
Sec. 2	*July 1, 2011*	New section
Sec. 3	*July 1, 2011*	New section
Sec. 4	*July 1, 2009*	20-7a

PH *Joint Favorable Subst.*